DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

v.

DPR CASE NUMBER: 90-13282
LICENSE NUMBER: ME 0030749

DALE G. MASSAD, M.D.

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board), telephonically on October 27, 1992, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides: "Respondent agrees never again to apply for licensure as a physician in the State of Florida."

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED,

That Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED.

DONE AND ORDERED this 5th day of November, 1992.

BOARD OF MEDICINE

ZACHARIAH P. ZACHARIAH, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by certified mail to Dale G. Massad, M.D., 115 Phillips Way, Palm Harbor, Florida 34683-1825, John D. Shofi, Esquire, P.O. Box 10430, Tampa, Florida 33679-0430 and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Department of Professional Regulation, Northwood Centre, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, at or before 5:00 P.M., this ____ day of _____, 1992.

DOROTHY J. FAIRCLOTH
Executive Director

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

CASE NO. 90-13282

vs.

DALE G. MASSAD, M.D.,

RESPONDENT.

_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against DALE G. MASSAD, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0030749. Respondent's last known address is 115 Phillips Way, Palm Harbor, Florida 34683-1825.

3. Respondent is a physician, who performs laser treatments to remove hemangiomas (port wine stains). Respondent has had five (5) years experience running a hospital emergency department and is board eligible in emergency medicine.

4. From on or about March 9, 1990, until on or about August 22, 1990, Patient #1 received four treatments from Respondent for removal of port wine stains by means of pulsed dye laser therapy.

5. Patient #1, a three (3) year old female, had been born with port wine stain birthmarks everywhere on her body except for her right arm.

6. On or about March 9, 1990, during her first treatment, Respondent gave Patient #1 an intramuscular injection of a combination of Demerol, 25 mg., and Phenergan, 25 mg. Respondent did not document Patient #1's weight to determine how much medication was appropriate for this child. The patient became hysterical.

7. Patient #1 continued the hysteria after she left Respondent's office and had nightmares all that night. Patient #1's mother communicated the child's behavior to Respondent, and Respondent said he would not use Demerol again but would use Valium.

8. On or about May 15, 1990, Patient #1 presented for her second treatment. Respondent gave her half of a Valium tablet, dosage unknown, in a glass of Coca Cola.

9. The Respondent had arranged for a dentist to perform a dental block on the patient during this treatment. Respondent and the dentist discussed the procedure; however, Respondent did not query the dentist on how much lidocaine the dentist was going to use on this child.

10. The dentist injected Patient #1 with twelve and one/half

(12 1/2) carpules, 1.8 ml./carpule, of 2% lidocaine with epinephrine at various locations on her face and inside her mouth while Respondent, the business representative, and the patient's mother held the patient down.

11. Respondent thereafter accomplished 1,395 laser pulses with that treatment.

12. Patient #1 was lethargic on the trip back to her grandparents' home, spent a restless night, and spiked a fever of 103.5 degrees through the night.

13. Respondent called the child's mother the evening after the treatment and again the next morning to check on the child.

14. On or about July 11, 1990, Patient #1 presented for her third treatment. Because the child did not want to drink the Valium in Coca Cola, Respondent injected her with 5 mg. of Valium.

15. After the child was carried upstairs, the dentist again gave Patient #1 a local anesthetic of eleven (11) carpules, 1.8 ml./carpule, of 2% lidocaine with epinephrine while the business representative and the child's mother held the child down.

16. After the local anesthetic was administered, the business representative carried Patient #1 back downstairs to Respondent's office. At that time, the mother mentioned that the child needed to cough. Respondent hit the child three (3) times on the back. The child coughed up mucus, saliva, and blood from where the dentist had worked inside her mouth, and said she was fine.

17. During the treatment, although the room was hot, the child shivered and shivered again. Respondent did not check the

child nor did he stop the treatment; however, he did acknowledge to the mother that he had seen the shivers.

18. Respondent completed 959 laser pulses on the third treatment.

19. After this treatment, Patient #1 awoke on the trip back to her grandparents' home and played with her sister that night.

20. On or about August 22, 1990, Patient #1 presented for her fourth treatment.

21. Respondent injected the child with Valium. The dentist injected as local anesthetic nine (9) carpules, 1.8 ml./carpule, of 2% lidocaine with epinephrine. Respondent was not present when the dentist injected Patient #1 with the lidocaine.

22. After the dental block had been completed, Patient #1's mother mentioned that the child needed to cough. The dentist picked up the child, took her to an office where there was a dental chair, began to suction her, and called for Respondent.

23. Respondent observed that Patient #1 was semi-conscious, lethargic, and she had a seizure.

24. Respondent and the dentist decided there was nothing to be done other than to monitor the child for further seizure activity and to get started on the laser treatment before the anesthetic wore off.

25. Patient #1 was carried back to the laser surgery room, and the child's mother observed that the child was blue. The dentist assured the mother that the child would be all right.

26. Oxygen was needed to treat the patient. No oxygen was

available.

27. Respondent monitored the child's pulse and respiration with a hand on her chest while he continued to use the laser on her.

28. Patient #1 gasped. Respondent began cardiopulmonary resuscitation (CPR); the dentist got the Ambu bag, and someone called 911.

29. When the paramedics arrived, Respondent asked for an endotracheal tube. The paramedics deferred to the expertise of Respondent on intubating the child.

30. CPR was stopped during the intubation procedure. After the tube was in, Patient #1 was hooked up to the ventilator. The placement of the tube was checked and found to be in the esophagus rather than the trachea. The child was extubated.

31. The child was not ventilated between the extubation and the second intubation, which was successful. The child was hooked up to the machine and oxygenated.

32. Patient #1's heart started beating again in response to a second dose of intravenous epinephrine.

33. Patient #1 was transported by the paramedics to the emergency room of a local hospital.

34. One hour and twenty minutes after arriving at the emergency room, Patient #1 was flown by helicopter to a children's hospital.

35. At the time of admission to the hospital, Patient #1's blood level of lidocaine was 8.6 mg./liter; the therapeutic level

is 1.5 to 5 mg./liter.

36. Patient #1 continued to deteriorate neurologically while in the hospital. After her blood level of lidocaine returned to within normal range and her phenobarbital and Dilantin levels were in the normal range, an examination revealed the child to be flaccid and to have no response to deep painful stimuli.

37. On or about the morning of August 25, 1990, with the parents' consent, the endotracheal tube was removed, and Patient #1 expired.

38. The cause of death was anoxic encephalopathy due to lidocaine toxicity.

COUNT ONE

39. Petitioner realleges and incorporates paragraphs one (1) through thirty-eight (38) above, as if fully set forth herein this Count One.

40. Respondent failed to practice medicine with that level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances in that Respondent took no vital signs preoperatively, intraoperatively, or postoperatively during any of the procedures.

41. Respondent did not have resuscitative equipment available in the treatment room at the time of the procedures. No supplemental oxygen was available.

42. Respondent did not recognize that the dose of lidocaine

being administered by the dentist was a toxic dose for Respondent's patient, a child.

43. Respondent did not recognize the early signs of lidocaine toxicity which the child presented, including drowsiness and early seizure activity. Had these signs been recognized and appropriate action taken, the cardiopulmonary arrest potentially could have been averted.

44. Respondent had had little training in the use of the pulsed dye laser. He read literature, observed for one day a physician at Duke University use the laser, and attended a one day seminar on laser surgery at the corporation which manufactured the equipment.

45. Based upon the foregoing, Respondent has violated Section 458.331 (1)(t), Florida Statutes, by gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

46. Petitioner realleges and incorporates paragraphs one (1) through thirty-eight (38), and forty (40) through forty-four (44) above, as if fully set forth herein this Count Two.

47. Respondent failed to maintain written medical records justifying the course of treatment of Patient #1, including but not limited to an inadequate medical history. There is no listing of allergies or current medications. There are no photographs or

documentation of the extent of the patient's port wine stain. No preoperative or postoperative vital signs are recorded. No weight for the child is recorded. There is no recording of the patient's response to therapy or detailing of the change in the port wine stain as it was treated.

48. Based upon the foregoing, Respondent has violated Section 458.331 (1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COUNT THREE

49. Petitioner realleges and incorporates paragraphs one (1) through thirty-eight (38), forty (40) through forty-four (44), and forty-seven (47) above, as if fully set forth herein this Count Three.

50. Respondent performed a procedure or prescribed a therapy which, by the prevailing standards of medical practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent in that prior to treating Patient #1, Respondent had not performed laser treatment with the patient under a dental block, nor did Respondent have any training in performing laser treatment with a dental block.

51. The Consent to Pulsed Dye Laser Therapy, which Patient #1's mother signed, was neither countersigned by Respondent as the

form provided nor was it dated.

52. The Consent to Pulsed Dye Laser Therapy does not mention specifically the use of a dental block as anesthesia. The consent form speaks in general terms about the anesthesias which may be used.

53. Based upon the foregoing, Respondent has violated Section 458.331 (1)(u), Florida Statutes, by performing any procedure or prescribing any therapy which, by the prevailing standards of medical practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent.

COUNT FOUR

54. Petitioner realleges and incorporates paragraphs one (1) through thirty-eight (38), forty (40) through forty-four (44), forty-seven (47), and fifty (50) through fifty-two (52) above, as if fully set forth herein this Count Four.

55. The Respondent has delegated professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them in that the Respondent allowed and/or directed an unlicensed or unqualified individual to administer anesthesia to Patient #1, a child.

56. Based upon the foregoing, Respondent has violated Section 458.331 (1)(w), Florida Statutes, by delegating professional responsibilities to a person when the licensee delegating such

responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 21 day of OCTOBER, 1991.

George Stuart
Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:
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Florida Bar No. 788643
LAQP/BWM
PCP: October 3, 1991
Burt, Campbell, Basisht

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK _____

DATE 10-23-91